CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

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OVERVIEW

Dental treatment covered by the Virginia Medicaid Program includes the following:

- Dental services for recipients under 21 years old
- Limited oral surgery for recipients age 21 and older

This chapter describes the Program coverage and limitations on dental treatment for each of these recipient groups.

PRE-AUTHORIZATION

Dental services requiring pre-authorization follow the instructions in Chapter V.

DENTAL SERVICES FOR RECIPIENTS UNDER 21 YEARS OLD

Definition

Dental services are defined as any diagnostic, preventive, restorative, or surgical procedures administered by or under the direct supervision of a dentist in the practice of his or her profession. **Such services include the treatment of the teeth and associated structures of the oral cavity and of disease, injury, or impairment which may affect the oral or general health of the patient.** Such services shall be maintained at a high standard of quality and be within the reasonable limits of those services which are customarily available and provided to most persons in the community with the limitations and exclusions as specified in this manual.

Standards of Service

Dental care furnished to covered recipients shall be in accordance with the ethical and professional standards of the dental profession. All materials used must meet the specifications established by the American Dental Association.

Medicaid recipients are to be treated in the same manner as private patients in conforming to established office policy.

Attending Dentists and Dental Treatment Plans

The dental provider should check with new recipients to determine if they have received services from another dental provider within the past year. If the provider suspects that the services to be performed have already been rendered by another provider

within the past year, he or she should request individual consideration and explain the situation under the Remarks section of the ADA Claim Form to avoid denial of the claim for services.

In the best interest of both the recipient and dental provider, all treatment plans should be completed as promptly as possible, preferably within 90 days of the beginning of treatment.

Basis of Payment

Reimbursement for covered services furnished under DMAS shall be the lesser of the individual dentist's usual and customary fee charged or the established reimbursement rate. While the provider's billed charges may not affect the current rate of reimbursement, DMAS will use the data for future adjustments to provider fees within available funding.

The maximum allowable payment to the provider shall constitute full payment for the covered services rendered, and no private agreement, transaction, or additional charge may be made by the dentist with or on behalf of the eligible recipient. Private arrangements with the recipient may be made **only** for **non-covered** services.

Payment will be made at the completion of treatment of any procedure only for services actually performed. If an eligible person does not return for completion of the treatment, only those procedures performed are to be indicated when requesting payment.

Payment will be made only for dental treatment completed prior to the date that the patient is no longer eligible. Payment, however, will be made for short-term multi-visit procedures, such as completion of a root canal, space maintenance, or prosthetic services which are initiated while the recipient is eligible but are completed after his or her eligibility expires. Providers, when billing for completion of such multi-visit procedures for recipients who are no longer eligible, should enter the date of the visit when treatment was started as the date of service on the ADA Claim Form. These circumstances should also be explained in the Remarks section of the ADA Claim Form.

The cost incurred by a provider for all laboratory procedures will be considered part of the provider's fee for services. The provider will be responsible for the payment of such debts to the dental laboratory.

Note: Except for the circumstances noted above, billing for services to receive payment **prior** to completion is considered misrepresentation.

Non-Covered/Incidental Services

In general, non-covered dental services include any services not listed in this manual as covered services either in this chapter or in Appendices B and C.

Examples of non-covered services are pulp vitality tests, occlusal adjustments, gingival curettage, prescriptions, biologicals or supplies, and cosmetic services such as tooth bleaching. Examples of incidental services are cavity liners and bases under restorations, local anesthesia, and minor scaling procedures associated with a routine prophylaxis. Note that the services listed on the previous page are only examples and are not intended to be a complete list of non-covered

or incidental services.

Note: Broken appointments are not considered services and are not to be billed to the patient or the Medicaid Program.

Patient education (D1330) is no longer a covered service effective for dates of service on and after July 1, 1998.

DMAS does not reimburse for broken appointments and appointments for which patients arrive late and were refused treatment. After instances of continual violation of established office policy, the dentist should report such occurrences to DMAS so that an investigation by the appropriate agency can be initiated. For example, if a recipient misses two or more appointments, his or her name and eligibility number may be mailed to:

Department of Medical Assistance Services
Recipient Services Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

DMAS will initiate an investigation, and a letter will be sent to each recipient.

The Medicaid dental program provides reimbursement to participating providers who render covered dental services in a proper dental setting to eligible Medicaid recipients.

Covered Services

Some dental services covered by DMAS do not require pre-authorization and some do. These services and requirements will be explained in this chapter.

Procedures Which Do Not Require Pre-authorization

Services listed in Appendix B of this manual do not require pre-authorization. These services are discussed in more detail later in this chapter.

Procedures Which Require Pre-authorization (PA) (also see Options to PA)

Services which require pre-authorization are listed in Appendix C of this manual. These services are discussed in more detail in the following sections of this chapter. For pre-authorized services, the provider is required to submit a pre-authorization request with supporting documentation, including a suitable current radiograph when necessary.

In true emergency/urgent situations, the provider can submit an ADA Claim Form, by requesting individual consideration (IC) and attaching documentation, explaining the circumstances under the Remarks section, and mailing it to DMAS-Dental, P.O. Box 27431, Richmond, Virginia 23261-7431. If there is a question as to whether the service will be covered, call DMAS-Dental at (804) 786-6635 for verification.

Pre-authorization requests should include the following supporting data as it pertains to each

request:

- Age of the patient
- Oral hygiene habits of the patient
- Pertinent present and past dental history
- Patient's acceptance of the requested treatment
- Patient's chance for job placement
- Psychological benefits to the patient resulting from the treatment
- Condition of the patient's supporting tissues and abutment teeth
- Necessary mounted recent, dated radiographs showing all areas requiring treatment and cephalometric radiographs for orthodontia
- Diagnostic models for removable and fixed prosthodontia and tooth guidance
- Orthodontic diagnostic models for the evaluation of full banded orthodontics

Consideration for authorization shall be based upon the most feasible treatment fulfilling the requirements of the specific situation. Resin-based restorations, bonded bridges, and partial dentures will be considered by a Program dental consultant before the authorization of permanent crowns on anterior teeth and posterior teeth or conventional bridges in both anterior and posterior regions. The provider must provide appropriate written justification to support the requested services.

The appropriateness of the requested treatment will be reviewed by a Program dentist. A Program dentist may consult with the provider regarding any part of the request for further information about a particular service or discuss any changes necessary for processing requests.

Note: Dental care to support covered services for which no specific provisions are made in these regulations and procedures (those not listed as covered or non-covered in this chapter) may be considered for pre-authorization on an individual basis by special request if justified and medically necessary through the EPSDT program.

Note: Option to Pre-authorization Requirement (Recipients under Age 21)

Effective for dental services rendered on and after July 1, 2002, that require pre-authorization (PA) listed in Appendix C of this manual, dental providers have the **option** to also perform and bill for these services in **non-urgent** situations without requesting and receiving pre-authorization. This option does not apply to full-banded orthodontic codes D8070 through D8090. Full-banded orthodontics still require PA. In addition, it is recommended that higher cost treatment services, such as orthognathic and TMJ surgery and removable or fixed prosthetic services where laboratory costs will be incurred, either be pre-authorized or discussed in detail

with the program dental consultant before rendering treatment.

Dental providers are to follow the same procedures used when submitting claims for services listed in Appendix C in justified urgent/emergent situations. Individual Consideration (IC) must be noted **in the Remarks section on the claim** along with supporting documentation included on or attached to the claims to enable the dental consultant to make a prompt coverage and payment decision. Similar criteria that is used in the PA process will be applied by the dental consultant when reviewing claims for payment. Therefore, a concise treatment narrative of clinical findings along with pre- and post-operative radiographs (readable copies are acceptable) should be provided as necessary to support claims for payment. **Radiographs will be required to support claims for endodontic, oral surgery, and prosthodontic treatment services. The patient's current oral hygiene status should be noted when requesting payment for more complex treatment such as root canals and crowns.**

Any questions as to whether a service requiring PA may be covered or about a previous coverage or payment decision should be directed to the program dental consultant at (804) 786-6635.

DETAILED INFORMATION REGARDING COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OLD

Diagnostic Services

Examinations

All dental examinations must be comprehensive and thorough inspections of the oral cavity. The **diagnosis, charting, pertinent medical and dental history, and recording** of the recommended treatment plan must be complete and of adequate clarity to permit a DMAS dentist, after reviewing the recommendations and any recent radiographs, to determine the appropriateness of the treatment plan without examining the patient.

All dental services performed must be recorded in the patient's chart, which must be available for three years, in accordance with the Virginia Board of Dentistry Regulations. According to DMAS regulations and accepted standards of professional care, an **initial** examination is not limited to a clinical examination of the dentition but should also include intra- and extra-oral soft tissue examination, blood pressure, pulse, and respiration rate for all patients, where appropriate.

Examinations are to be billed as follows:

- An **initial** (original) oral examination (D0150) for a given recipient is to be billed only **once** by the same provider or other providers in the same office.
- **Periodic** (recall) examinations (D0120) are limited to one every six months following the initial oral examination.
- An **emergency/limited** oral examination (D0140) may be billed as necessary, with the exception that it may not be billed on the same date that another dental examination (D0150 or D0120) was performed by the same provider or other providers in the same office.

Radiography and Interpretation

Diagnostic radiological procedures, in accordance with current ADA guidelines, are to be limited to those instances in which a dentist anticipates the information is likely to contribute materially to the proper diagnosis, treatment, and prevention of disease. **The radiographs should show all areas where treatment is anticipated** and should be submitted for all services requiring x-ray interpretation for preauthorization.

All current original or duplicate radiographs for pre-authorized procedures must be suitable for interpretation; identified with the patient's name, date, name of the dentist; and marked "right" and "left." Four or more radiographs must be properly mounted. Films technically unacceptable for proper interpretation, which are submitted for pre-authorization, will be returned for replacement at no additional cost to the Program and must be submitted with a new pre-authorization request. Films submitted for pre-authorized services done in emergency situations, which are unacceptable for review of these services, will result in a voided payment.

Adequate records including radiographs are to be maintained by the dentist providing treatment and to be available for inspection for three years.

Reimbursement for radiological procedure codes D0210 **or** D0330 is limited to once every three years. Reimbursement will be made for only **one** of these codes every **three** years.

- A **complete series** (D0210) consists of a minimum of two bitewing films and ten periapical films for anterior, posterior, or occlusal views.

- A single **panoramic film** (D0330) is a covered service normally limited only to emergency situations, such as fractures of the jaw, suspected pathology/dental anomalies, or surgical extractions of third molar impactions; it is **not** reimbursable in combination with procedure code D0210. The use of D0330 in addition to a full series within a three-year period will be scrutinized by a Program dentist for medical necessity. **The use of D0330 with bitewing and/or periapical films as a <u>full mouth series</u> should be billed as D0210.**

Reimbursement for individual **periapical** radiographs (D0220 and D0230) will generally be limited to those radiographs necessary to make an adequate diagnosis in accordance with ADA guidelines. Payment will be limited four films per visit.

If more than three additional periapical films (D0230) are necessary, the provider must explain the necessity for more films under the Remarks section of the ADA Claim Form.

Procedure code D0270 for one **bitewing**, D0272 for two **bitewing** radiographs **or** D0274 for four films may be taken once per year.

On certain occasions, postoperative bitewing and/or periapical radiographs will be requested by DMAS for utilization and quality control, e.g., root canal therapy.

Please Note: When making referrals, the referring dentist should, when feasible, send to

the specialist any current radiographs to prevent the unnecessary duplication of services, expenditures, and radiation exposure.

Preventive Dental Care

In addition to a dental examination every six months, preventive dental care may encompass the following recommended services.

Prophylaxis (Every six months) (Including minor scaling procedures)

Procedure code (D1110) is used when billing an adult prophylaxis for recipients age 13 through age 20.

Procedure code (D1120) is used when billing a child prophylaxis for recipients age 12 and under.

Fluoride Treatment (Every six months)

Topical fluoride treatment or oral fluoride medication should be administered in accordance with appropriate standards. Fluoride in prophy paste is **not** considered a fluoride treatment.

Procedure code (D1204) is used when billing for adult fluoride treatment for recipients age 13 through age 20.

Procedure code (D1203) is used when billing for child fluoride treatment for recipients age 12 and under.

Sealants (Once per tooth)

A) Sealants are covered only **once per tooth** on the occlusal **or** occlusal facial surfaces of the first and second permanent mandibular molars (tooth #18, 19, 30, 31) and the occlusal **or** occlusal lingual surfaces of the first and second permanent maxillary molars (tooth #2, 3, 14, 15) that have deep narrow pits and fissures that are difficult to clean and have a high risk of caries. Sealants are not covered for anterior teeth, premolars or third molars.

B) Coverage is limited to one sealant per tooth. Sealants placed on the same surface(s) of previously-restored teeth are not covered. Sealant repair or replacement will be at the provider's expense. Exception: Consideration of coverage may be given if the sealant is replaced by a different dentist and justified in the "Remarks" section of the claim.

C) Sealants are only covered for recipients age 5 through age 20. Sealants are not covered for patients age 4 and under unless individual consideration is requested, and written justification supporting the medical need for such services is noted in the "Remarks" section on the claim for payment.

D) When billing, providers must use the American Dental Association (ADA) procedure code D1351 for each sealant per tooth and are encouraged to identify the surfaces

sealed (O or OL or OF or OB). Teeth should be completely erupted before the sealant application so the entire surface(s) can be sealed at one time.

DMAS will monitor the effectiveness and appropriateness of dental sealants through an analysis of the paid claims for preventive and restorative procedures on permanent molars and by random or selected dental audit.

Automatic Recall

Participating dentists are encouraged to extend automatic recall procedures to covered persons, not to exceed one recall every six months. Providers should not recall the patient prior to six months from the last treatment date.

Restorative Treatment

Restorative treatment is limited to those services essential to restore and maintain adequate dental health. Pre-authorization is not required for most of the services under this section. Once a particular restoration has been placed in a tooth (e.g., occlusal, MOD), payment for that restoration will generally not be made again for **at least three years**. In some cases, when recurrent decay develops or a restoration is fractured, the provider may receive payment by explaining the situation under the Remarks section of the ADA Claim Form.

Routine Restorations

Generally, the Program will not provide reimbursement for restorations placed in primary cuspids and molars of children beyond the twelfth birthday, or in primary incisors beyond the fifth birthday, or where exfoliation is imminent. Exception: Coverage may be considered for retained primary teeth for recipients age 13 and older if permanent teeth are congenitally missing and the teeth are functional.

For routine restorations, resin-based composite restorations (D2330 to D2390) are to be used for the 12 **anterior** teeth and amalgam restorations (D2140 to D2161) or composites (D2391 to D2394) are to be used for the posterior teeth. Exceptions to this policy include:

- Amalgam may be used for restoring distal (D) surfaces of cuspids and lingual (L) surfaces of anterior teeth.

- Resin-based composite materials may also be used for restoring, **one**, **two**, **three, and four** surfaces on **posterior** teeth with narrow buccolingual preparations.

Note that reimbursement for resin restorations **includes etching, adhesive bonding, and light curing.** For those instances in which a posterior composite meets the above exceptions, use procedure codes D2391 through D2394. D2161 should be used for large 4+ surface posterior tooth restorations.

A sedative filling (D2940) is considered a temporary restoration only and **not** as a base or pulpcap under a permanent restoration.

Linings or bases are to be provided under all restorations as required by good dental practice. **DMAS considers cavity liners and/or intermediate bases to be part of the restoration and not a separate reimbursable service.**

Consideration of additional reimbursement for the treatment of an **exposure** or a **near exposure** of vital pulp tissue (pulp caps) will be on an **individual consideration** (IC) basis. Procedure codes D3110 and D3120 may be billed as separate procedures for pulp capping.

DMAS will reimburse for only one single surface restoration per tooth surface. For example, two separate occlusal (O) restorations on the same tooth are to be billed as one occlusal restoration. However, it is permissible to bill for multiple, but separate, restorations involving the same tooth surface, such as a mesial-facial (MF) and distal-facial (DF) restoration on the same anterior tooth.

Pins used for retention of a restoration (D2951) are billed separately from the restoration and do **not** require pre-authorization.

Permanent Crowns (Pre-authorized Service)

- Permanent crowns should be requested only for permanent teeth of strategic importance, such as maintenance of an intact dental arch or needed as a retainer for partial dentures. The condition of the remaining teeth, oral hygiene, and periodontium must justify the need for this treatment.
- The recipient should be 16 years of age or older. Crowns for younger recipients will only be considered for endodontically-treated permanent teeth.
- Fracture or substantial loss of tooth structure should be evident before crown treatment is considered. Radiographs must be submitted to support the request.
- Permanent crowns should only be requested when pre-formed resin crowns, bonded/acid etch resin restorations, or stainless steel crowns will not adequately accomplish treatment objectives. **Justification must be provided to support the treatment using permanent crowns over alternative less costly services, or requests for additional information will be made.**
- Only permanent cast crowns of noble (semi-precious) and base (non-precious) materials will be covered.
- Porcelain crowns are not covered.
- Reimbursement for permanent crowns includes all laboratory services and temporary coverage.

Other Crowns (Non-Pre-authorized Service)

Pre-fabricated resin crowns (polycarbonate) (D2932) and resin-based composite crowns (D2390) may be used as restorations for severely-fractured or carious **permanent** anterior teeth. For

primary anterior teeth, the following is to be considered when using polycarbonate or resin-based composite crowns:

- Teeth with one-half or more of their roots remaining (approximately two years left before exfoliation)
- Teeth cariously involved on more than one surface
- Teeth pulpally involved

Pre-fabricated stainless steel crowns may be used for primary and permanent teeth. For primary teeth, use procedure code D2930; for permanent teeth, use D2931.

Endodontia

Root Canal Therapy (Pre-authorized Service)

Root canal therapy is a pre-authorized service. The reimbursement for endodontic treatment includes all necessary working length radiographs and procedures during treatment, including postoperative radiographs. Preoperative and postoperative radiographs must be kept on file with the patient's chart for a period of at least five years.

Root canal therapy (D3310 to D3330) for permanent teeth includes extirpation and treatment with ADA-approved materials and all necessary radiographs, including a post-treatment radiograph. Permanent teeth filled with non-approved materials will **not** be considered standard root canal therapy and, therefore, will not be covered by DMAS.

For root canal therapy initiated but not completed for some reason, the provider should bill for partial payment only. DMAS will allow a percentage of the maximum allowable reimbursement in these situations. Identify these situations by requesting individual consideration (IC) and explaining in the Remarks section of the ADA Claim Form why the treatment could not be completed.

For **apexification** procedures, use procedure codes D3351 - D3353. If for some reason, treatment is not completed follow the billing process noted above.

For an emergency endodontic procedure, open tooth to drain (use D3221). It may only be performed **prior** to root canal therapy when it is necessary to relieve pain or infection and not as the first treatment phase for routine (2) visit endodontic treatment or when root canal therapy is completed the same day as the emergency visit. Therefore, a pulpectomy (D3221), pulpotomy (D3220), or palliative treatment (D9110) is not to be billed in conjunction with routine root canal therapy (D3310 to D3330).

NOTE: Pulp capping treatment of small pulpal exposures either mechanical or exposed in final caries removal should always be considered prior to root canal therapy in teeth that have not shown previous pulpitis symptoms.

Posterior endodontics may be authorized on a very limited basis. Requests for endodontics for

posterior teeth will be considered based on the following:

- The patient must display excellent oral hygiene and awareness of the importance of good dental care.
- All requests will be considered on an individual basis. Appropriate radiographs should be enclosed with the pre-authorization request. The x-ray(s) submitted must clearly show the apices of the teeth for which treatment is requested. Although DMAS covers posterior endodontics on a limited basis, it expects the provider submitting the request to be very selective so that this service may be continued.

A standard of acceptability employed by DMAS for endodontics requires that the completed root canal filling be of inert, non-resorbable materials (e.g., gutta percha extending to the apex (apices) of the tooth and completely filling all canals laterally). **A radiograph demonstrating the completed endodontic therapy is required to be a part of the clinical procedure and, therefore, a part of the clinical record.** In cases where the root canal filling does not meet minimum DMAS technical standards, at its option DMAS may:

- Require the procedure to be redone at no additional charge;
- Deny reimbursement for the service; or
- Recover reimbursement already made for the service.

Pulpotomy/Pulpectomy

A **pulpotomy** (D3220) will be limited to a deciduous tooth or a permanent tooth with incompletely-formed roots. Pre-operative and post-operative radiographs are to be kept in the recipient's file.

Note: For pulpal therapy or a so-called **pulpectomy** for **deciduous teeth**, using cement or paste-type fillers, use D3230 or D3240. Do not use endodontic procedure codes (D3310 – D3330) for primary teeth pulpectomies.

Apicoectomy (Pre-authorized Service)

An **apicoectomy** (D3410, D3421, D3425, and D3426) includes any necessary curettage and will be considered for approval only if one or more of the following conditions exists:

- Overfilled canal
- Canal that cannot be filled properly because of excessive root curvature or calcification
- Fractured root tip that cannot be reached endodontically
- Broken instrument in canal
- Perforation of apical third of canal

- Radiographs or symptoms indicating failure of root canal therapy

Pre-operative and post-operative radiographs are required records for apicoectomies.

A **retrograde filling** (D3430) may be placed when necessary and billed separately.

Periodontal Treatment (Pre-authorized Service)

Gingivectomies and scaling and root planing are only pre-authorized on a very selective basis. These services are considered to be one procedure regardless of the number of visits. Indicate which quadrants are to be treated, add a detailed description, and attach radiographs.

Gingivectomies (D4210) or (D4211)

Gingivectomies for the removal of hyperplastic tissue to reduce pocket depth should only be requested when non-surgical treatment does not achieve the desired results or when the patient is being treated with medications that result in such conditions. When requesting pre-authorization, indicate the pocket depths, **number of affected teeth,** and any other conditions, and previous treatment performed to reduce the pocket depth.

Scaling and Root Planing (D4341) or (D4342)

When requesting pre-authorization for definitive scaling **and** root planing, indicate the extent of calculus and plaque formation. This procedure is to be requested only for severe periodontal conditions (i.e., late Type II, III, IV periodontitis) where definitive comprehensive root planing is required in addition to gross debridement requiring local/regional block anesthesia and several appointments. Indicate such situations with the request for treatment, the quadrants and **number of teeth actually affected,** and the number of planned treatment visits, along with periodontal pocket depth charting and the condition of the gingival tissue and/or periodontium and appropriate x-rays must be submitted to support the request.

Full Mouth Debridement (D4355)

When requesting pre-authorization for this procedure, indicate the extent of calculus and plaque formation and **justify the need** for this service over minor scaling procedures generally associated with a prophylaxis. This procedure is to be requested only when there is substantial gingival inflammation (gingivitis) in all four quadrants and can usually be performed in one appointment with or without anesthesia. This code, like D4341, is priced by quadrant. Therefore, each quadrant should be billed separately. This allows coverage for debridement if less than full mouth.

Prosthodontic Treatment, Removable (Pre-authorized Service)

- Dentures, both partial and complete, will be considered for pre-authorization when submitted evidence indicates that masticatory deficiencies are likely to impair the general health of the patient.

- The agency will pay particular attention to the following factors when reviewing pre-authorization requests for this service:
    - Age, school/employment status, and rehabilitation potential of the patient (e.g., the provision of dentures will enhance vocational placement);
    - Medical status of the patient (the nature and severity of disease or impairment) and psychological predisposition;
    - Condition of the other oral cavity structures, including abnormal soft tissue or osseous conditions;
    - Past experience with dentures, if applicable, such as lost or broken dentures; and
    - Condition of present denture, if applicable.
- Authorization for partial dentures to replace posterior teeth will **not** be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. For partial dentures, two or more posterior teeth must be missing in a quadrant or at least one posterior tooth in each quadrant of the same arch.
- Authorization for cast partial dentures for anterior teeth generally will not be given unless two or more anterior teeth in the same arch are missing. A modified space maintainer is to be considered when only one anterior tooth is missing in an arch.

  Dentures will **not** be pre-authorized when:
    - Dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or
    - Repair, relining, or rebasing of the patient's present dentures will make them serviceable.
- Normally, dentures will **not** be pre-authorized until three (3) months after the last extraction. Please note if an immediate denture is necessary.
- Diagnostic models must be submitted, **if requested**, with all removable denture pre-authorization requests, properly marked with provider and recipient names and numbers. They must be properly trimmed and packaged in appropriate containers to prevent breakage and mailed under separate cover to: WVMI, 6802 Paragon Place, Suite 410, Richmond, Virginia 23230. Models will be returned in the same containers as received. Unacceptable models will be returned for replacement and resubmission at no additional cost to the Program. The request and models must be re-submitted for review and consideration of coverage.
- Partial dentures must be described in detail indicating the material to be used,

position of clasps, and teeth to be replaced.

- Denture repairs are allowable.
- The payment for all dentures will include models, laboratory costs, and necessary adjustments including relining for a six-month period.
- After the initial denture, another one will **not** be pre-authorized for a minimum of **five (5) years**, except in unusual circumstances. The provider must justify the need for any new denture.

Prosthodontic Treatment Fixed (Bridges) (Pre-authorized Service)

Fixed bridges will **only** be covered under special circumstances when no other acceptable less expensive dental service will adequately accomplish the treatment objectives. Only bridges with cast retainers or crowns of noble (semi-precious) and base (non-precious) materials will be covered.

Maryland or Virginia resin (bonded) retainers (D6545) for bridges and partial dentures should initially be considered as less costly alternatives to traditional fixed bridges where sound tooth structure and occlusion permits. Justification of the conventional fixed prosthesis over a less costly alternative must be provided with the request for coverage. Candidates for any fixed prosthetic appliances must have demonstrated very good to excellent oral hygiene practices and dental health awareness. A fixed prosthesis will only be approved, when justified, to replace **one** or **two** missing anterior teeth or where only **one** posterior tooth is missing. Exceptions to this policy may be made on an individual consideration basis.

A full series of radiographs or panorex is required to be submitted to support the treatment request.

If a prosthetic request is denied, **acceptable** models, **if requested** by DMAS and used in the evaluation, may be billed on the ADA Claim Form. Note this in the "Remarks" section and attach a copy of the denial to ensure payment.

Exodontia and Oral Surgery (Including Biopsy and Tissue Examination)

Exodontia

Current dated original radiographs or readable duplicates (with original date) are required for **all teeth that need to be extracted**. These are to be kept with the patient's permanent record for five years.

The **routine** extraction of teeth does not require pre-authorization. In cases where an apparent routine extraction requires a mucoperiosteal flap and/or tooth sectioning for removal, the provider should bill the service as procedure code D7210 and explain the situation under the "Remarks" section of the ADA Claim Form. The routine extraction of teeth includes elevator and/or forcep extractions of erupted third molars, procedure code D7140. The routine use of procedure code D7210 for erupted third molars is not acceptable unless a mucoperiosteal flap

and/or bone removal/tooth sectioning is required for extraction.

The extraction of **impacted** teeth may be pre-authorized only when conditions arising from such impactions warrant their removal. These conditions are pain and/or infection. When requesting approval for this procedure, the provider should note these conditions on the pre-authorization request. The **level** of requested impaction for approval of payment must be supported by the accompanying radiograph(s). In an emergency, the provider should explain the situation under the "Remarks" section of the ADA Claim Form, attach radiographs (mounted, if two or more), and mail to: DMAS-Dental, P.O. Box 27431, Richmond, Virginia 23261-7431.

The extraction of **supernumerary** teeth is a covered service using tooth codes #51 - #82 for permanent teeth and #AS - #TS for primary teeth and the appropriate procedure code (D7140 to D7241). To bill for this service, the provider should obtain pre-authorization. However, in emergency situations, use the appropriate tooth and procedure codes and, under the Remarks section of the ADA Claim Form, indicate the number and location of the supernumerary teeth extracted. All claims must include supporting radiographs and be mailed to: DMAS-Dental, P.O. Box 27431, Richmond, Virginia 23261-7431.

NOTE: The extraction of teeth includes any routine removal of granulomatous or cystic lesions, tooth follicule(s) and placement of necessary sutures. The use of other procedure codes for services in addition to extraction codes, such as the removal of a large dentigerous or eruption cyst, must be medically-justified and supported by written and radiographic documentation to be considered for coverage and reimbursement.

Oral Surgery

Requests for oral surgery procedures should be detailed and specific, giving the diagnosis, measurements, etc. Because non-routine oral surgery procedures are more costly than routine care, most of these procedures have been placed on pre-authorization. DMAS, however, realizes that many of these procedures will probably be performed on an emergency basis. Dentists should continue to contact a Program dentist when practical to verify coverage and obtain verbal approval before rendering services. When these situations arise, the dental provider may use the ADA Claim Form, and fully explain the circumstances involved under the "Remarks" section, and mail the invoice, with supporting documents, to: DMAS-Dental, P.O. Box 27431, Richmond, Virginia 23261-7431.

When requesting pre-authorization for orthognathic surgery, the provider must submit cephalometric xrays, articulated models, and photos.

Biopsy and Tissue Examination

The incisional and excisional biopsy of tissues (D7285 and D7286) and tumor removal (D7410 to D7465) refers to the surgical procedure only and is to be billed to DMAS as that surgical procedure.

The histopathologic examination (D0473) is a separate procedure from the biopsy and is to be billed by the provider (pathologist) performing that service. The recipient's name and complete Medicaid eligibility number must be provided with or on the Request for Tissue Examination

form when submitting a specimen for examination and evaluation to the pathologist. The pathologist will be responsible for billing this procedure.

Orthodontic Treatment (Pre-authorized Service)

- Minor tooth guidance will be authorized on a selective basis to help prevent the future necessity of full banded orthodontia. All appliance adjustments are incidental to and included in the allowance for the tooth guidance appliance.

- Full banded orthodontic treatment will only be pre-authorized on a **very selective and medically necessary basis**. The determination of the need for orthodontic treatment will be based on the assessment of whether a **handicapping malocclusion is affecting the patient's health. Treatment for cosmetic purposes is not covered.**

- The Salzmann Evaluation Method, which measures the degree of **permanent dentition** malocclusion, is used as a basis for determining whether Medicaid recipients qualify for full banded orthodontic treatment. Points are scored by consulting orthodontists using the appropriate radiographs and diagnostic models. The following criteria are used for determining qualification:

  - Twenty-five (25) points are necessary to qualify for coverage and payment.

  - Five (5) points toward the 25 points will be awarded for surgical orthodontics (e.g., resections). Specify when necessary.

  - Points are not awarded for **esthetics**. Thus, the additional eight (8) points for handicapping esthetics used by Salzmann will not be considered.

  A copy of the original Salzmann article is found in Appendix F.

- An orthodontist should only accept referrals from private or public health dentists who have evaluated a patient's potential need for orthodontia. The patient should have had an initial evaluation from a referring general dentist as to his or her oral hygiene and willingness to follow treatment procedures. An orthodontist should make a cephalometric analysis and diagnostic models **only** if the provider feels that the patient may qualify for orthodontic coverage. Refer to the Salzmann Evaluation Method to make a preliminary analysis for potential coverage. **Remember that the evaluation is for permanent dentition. The request should not be submitted until the majority of permanent teeth have erupted to ensure a proper evaluation can be made by the consultant.**

- The orthodontist should not proceed with making records without consulting with the referring dentist if there are questions about the severity of the case, the oral hygiene status and habits, or the patient's ability to cooperate or to complete treatment. If after conferring, it is felt the patient is not a good risk, that treatment will not benefit the patient, or the case should be delayed until a more permanent dentition erupts,

the treatment should not be requested, and the patient should be made aware of this decision.

- Direct questions concerning recipient eligibility to the **Audio Response System (ARS)** at the following numbers:

1-800-884-9730	All other areas (in-state, toll-free long distance)
1-804-965-9732	Richmond area and out-of-state long distance
1-804-965-9733	Richmond area and out-of-state long distance

  Recipients are **not** eligible for orthodontics after they have reached their twenty-first birthday.

- Submit **a completed** pre-authorization request with the following information:

  - The appropriate procedure code for the requested orthodontic treatment
  - The patient's age and expected cooperation
  - An estimated total treatment fee, including all of the **necessary** diagnostic and treatment services. **(Do not request authorization for diagnostic records at this time.)**
  - A **brief outline** of the **treatment plan** including the expected length of treatment. Indicate if special skeletal surgical intervention will be required. Information should be detailed enough to support requests and to enhance the consultant's review.

    The models and cephalometric radiograph/analysis and panorex, if needed, and any other written supporting documentation should be sent with the pre-authorization request for review by one of the DMAS orthodontic consultants. The models must be placed in appropriate containers and properly marked with the provider and recipient names and numbers, and sent to: WVMI, 6802 Paragon Place, Suite 410, Richmond, Virginia 23230. Models unacceptable for evaluation will be returned with the request for replacement at no additional cost to DMAS. A new request and models must be re-submitted for review and consideration of coverage.

- For cases that do not meet the Salzmann criteria for approval, additional medical necessity information, such as speech, eating or emotional disorders, will be requested in the evaluation process.

- If the case is approved, the pre-authorization request will be processed and an approval letter sent to the orthodontic provider (with a note explaining the consultant's evaluation.) An authorization number and the maximum treatment allowance will be sent to the provider by the fiscal agent for use in submitting a claim. **The reimbursement for approved cases includes all diagnostic services, treatment and retention phases, and are not to be billed separately for**

additional reimbursement.

- Cosmetic appliances are not covered and consideration of reimbursement for lost or broken retention appliances will be on a medically-necessary, individual-consideration basis.

- If the request is denied, the orthodontic provider may bill for the diagnostic models and cephalometric radiograph/analysis and any other necessary or requested radiographs needed for evaluation on a ADA Claim Form. Note individual consideration (IC) in the "Remarks" section and attach a copy of the denial letter to ensure payment. **Additional records, such as photographs or a panoramic film, not needed or requested for orthodontic coverage evaluation, are not covered as separately-billed services.**

- Reimbursement for approved services, will be paid on a quarterly basis. Claims for payment should be billed at the beginning of each quarter. Forty percent of the total bill should be submitted on the first invoice and twenty percent each subsequent three-month period until full payment is received. Post-treatment stabilization retainers and follow-up visits are included in the reimbursement for orthodontic services.

- If a patient becomes ineligible during treatment and treatment is still being provided, contact a Program dentist to determine the appropriate billing procedure to continue receiving payment. **The provider should notify the patient of this requirement before beginning treatment.**

- Notify DMAS-Dental if the patient moves to another locality, so financial arrangements can be made to help assure the completion of treatment.

Other Services (Pre-authorized Services)

Space Maintenance

Space maintainers (D1510 to D1525) require pre-authorization, and mounted bitewing radiographs must accompany the request for this service. If approved, the date of service on the ADA Claim Form should reflect the date the appliance is inserted unless treatment was started but not completed prior to the end of a recipient's eligibility.

Anesthesia

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made.

General anesthesia (D9220) and D9221) should be pre-authorized and will be subject to the following conditions:

- This service is not routinely authorized for the apprehensive dental patient. This service is limited to prolonged or involved procedures, such as full mouth extractions

and severely-impacted teeth.

- The necessity must be demonstrated.
- The physician or dentist, who administers the anesthesia and who remains in constant attendance during the surgical procedure for the sole purpose of rendering the anesthesia service, should bill for those services on his or her ADA Claim Form. When no other dentist or physician is present, the provider of the dental services who assumes the responsibility for the monitoring and supervision of the anesthesia may bill for the general anesthesia.
- When billing for general anesthesia using only D9220, the **total time** in minutes the patient was under anesthesia and the type of anesthetic agent(s) used are to be placed under the "Remarks" section of the ADA Claim Form. (For balanced anesthesia, use the same procedure code as for general anesthesia, D9220, and note which anesthetic agents were used.)

  Note: You may also use D9221 for each additional 15-minute time unit along with D9220 for the first 30 minutes of anesthesia. **Do not use D9221 if you use D9220 with total time for anesthesia services noted in the "Remarks" section of the claim.**

The "**routine**" administration of **inhalation analgesia** (nitrous oxide) is generally considered part of a treatment procedure, and no additional payment will be made. There may be situations where a patient is unmanageable in the office using local anesthesia; in such cases, to prevent hospitalization, nitrous oxide may be billed using procedure code D9230 and explaining the circumstances under the Remarks section on the ADA Claim Form.

In the event that Non-intravenous Conscious Sedation is necessary to manage a patient, use procedure code D9248. This code includes the administration of sedative and/or analgesic agent(s) by a route other than IV; (PO, PR, Intranasal, IM) and appropriate monitoring. The use of D9248 must be documented in the dental record to include the medical necessity, and the monitoring of the enrollee. **If not pre-authorized**, an explanation of the billed D9248 must be documented in the Remarks portion of the ADA Claim Form.

In office intravenous conscious sedation, procedure code D9241, may also be covered if medically necessary to prevent hospitalization and should be **pre-authorized** with the proper medical explanation of need. The medical record documentation in the dental record should contain the drug(s) used, the monitoring of the enrollee, and the staff present to manage the enrollee.

For **non-sedated** difficult behavior management problems requiring extra time, constraints, etc., use procedure code D9920.

When billing Behavior Management, procedure code D9920, in **conjunction** with D9230 and/or Anesthesia codes, D9241 or D9248, medical necessity must be documented in the "Remarks" portion of the ADA Claim Form that explains why a combination of procedures were necessary.

DMAS follows the Regulations set forth by the Virginia Board of Dentistry (18 VAC 60-20-110 through 18 VAC 30-20-130) and The American Dental Association Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999.

Hospital operating room cases are covered if medically-justified for that setting. Use procedure code D9999 for all services connected with same-day surgery. This includes the initial hospital care, history, examination, initiation of diagnostic and treatment programs, preparation of hospital records, consults with anesthesia and/or pediatrician and others, day surgery visit, and hospital discharge day management including the discharge summary. These procedures should be specified on a pre-authorization request. If not pre-authorized, request individual consideration (IC) and explain the above in the "Remarks" section of the ADA Claim Form.

Hospital/Surgical Center Setting

General medically justified indications/criteria must be met for utilizing the operating room to provide dental treatment under general anesthesia.

1. Patients with certain psychological, emotional maturity, physical, mental or medically compromising conditions;
2. Patients with dental needs for whom local anesthesia or other sedative techniques are ineffective;
3. The extremely uncooperative, fearful, anxious, or physically resistant patient with substantial dental needs;
4. Patients who have sustained extensive orofacial or dental trauma; or
5. Patients requiring significant surgical procedures or have dental needs who otherwise would not receive comprehensive care.

Note: General anesthesia services, if available and medically feasible, in the office setting, should be attempted or considered before requesting or providing treatment in the hospital/ambulatory surgical center setting.

For each subsequent hospital visit (up to a maximum of three) for the same stay, use procedure code D9420. For outpatient hospital care follow-up, use procedure code D9930. These codes should be pre-authorized but can be billed with a brief explanation in the "Remarks" section of the ADA Claim Form.

Professional Visits (D9410)

Non-emergency home visits or treatment of patients in licensed medical institutions, nursing facilities, homes for the aged, boarding homes, or any site other than the provider's usual place of practice should be pre-authorized.

Hospital Dental Services (D9420)

Non-emergency hospital visits for dental services should be pre-authorized, and the necessity for admission must be demonstrated.

Hospitals and Outpatient Clinics

State and federal clinics or institutions, hospitals, and outpatient departments of hospitals will follow the same procedures stated in this manual.

Non-Specific Procedure (To Be Used When Specific Codes Are Not Applicable)

Palliative treatment	D9110	(non-pre-authorized)
Behavior management	D9920	(non-pre-authorized)
Post-op treatment, non-routine	D9930	(pre-authorized)
Unspecified treatment	D9999	(pre-authorized)

If there is a question whether a non-specific procedure is covered, the provider should contact the **DMAS Dental Program at 804-786-6635** prior to performing the service.

If the procedures listed above are performed on an emergency basis, a complete explanation of the specific treatment rendered for these procedures must be stated under the Remarks section of the ADA Claim Form.

LIMITED ORAL SURGERY FOR RECIPIENTS AGE 21 AND OLDER

Overview

Oral surgery is covered for recipients 21 years of age and older when performed by a participating dental surgeon and **only** when the service is one which is generally covered under Title XVIII (Medicare) or is deemed medically necessary. It is expected that most oral surgery for this age group will be performed in a hospital and **will require pre-authorization**. See Chapter V for special billing instructions for recipients for 21 years and older.

Service Limitations and Non-Covered Services

Items and services connected with the care, treatment, filling, removal, replacement of teeth, or structures directly supporting the teeth are not covered, except for extraction of teeth prior to radiation therapy. "Structures directly supporting the teeth" are defined as the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process.

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is **not** covered. Similarly, an alveoloplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures.

Whether or not such services as the administration of anesthesia, diagnostic radiographs, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, a radiograph taken in connection with the reduction of a fracture of the jaw or facial bone would be covered. However, a single radiograph

or radiograph survey taken in connection with the care or treatment of teeth or the periodontium would not be covered.

Covered Services

Payment may be made for (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose. Other medical conditions that meet the DMAS definition of medical necessity are also covered.

Examples of other **medically**-related covered services include osteotomies, cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, extraction of teeth for severe abscesses complicating the patient's health or management of a medical condition, and radiographs needed to diagnose the above conditions. **Pre-authorization is required unless treatment is performed and necessary in urgent situations.**

For recipients age 21 or over who require medically-justified hospitalization for their dental services, the anesthesiologist and hospital will be covered; however, only those limited oral surgical procedures listed above will be covered for the dentist.

If an otherwise non-covered procedure or service is performed by a dentist incident to and as an integral part of a covered procedure or service performed by him or her, the total service performed by the dentist on such an occasion is covered. For example, the reconstruction of a ridge performed primarily to prepare the mouth for dentures is a non-covered procedure. However, where the reconstruction of a ridge is performed as the result of and at the same time as the surgical removal of a tumor (for other than dental purposes), all surgical procedures would be covered.

The extraction of teeth to prepare the jaw for radiation treatments of a neoplastic disease is covered. This situation is an exception to the requirement stated in the section above that, to be covered, a non-covered procedure or service performed by a dentist must be incident to and an integral part of a covered procedure or service performed by the dentist. Ordinarily, the dentist extracts the patient's teeth but another physician (e.g., a radiologist) administers the radiation treatments.

BILLING

Each line of the ADA Claim Form for services rendered to recipients age 21 or over, **must** have an explanation provided under the "Remarks" section or in an attachment (including the age of the recipient) **if** there is no authorization number or other approval given for billing purposes.

PRESCRIPTION SERVICES

Although DMAS does not reimburse dentists for writing prescriptions, all dentists must include their Medicaid provider numbers on all Medicaid prescriptions. Dentists are requested to write generic prescriptions where possible. The next section describes this in detail. They should specify a name brand only when medically necessary. The pharmacy will fill the prescription and bill Medicaid on the Daily Drug Claim Ledger (DMAS-173 R-9/78).

Multiple Source Drugs - Payment Basis

Under the authority of 1902 (a) (30) (A) and the regulations in 42 CFR 447.332, the Health Care Financing Administration (HCFA) establishes a specific upper limit for certain multiple-source drugs if the following requirements are met:

- All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication *Approved Drug Products With Therapeutic Equivalence Evaluations* (including supplements or in successor publications). See Appendix E for an explanation.

- At least three suppliers list the drug, which has been classified by the FDA as category "A" in its publication *Approved Drug Products With Therapeutic Equivalence Evaluations* (including supplements or in successor publications), in the current editions (or updates) of published compendia of cost information for drugs available for sale nationally (*e.g., Red Book, Blue Book, Medi-Span)*.

The upper limit for multiple-source drugs for which a specific limit has been established does not apply if a dentist **certifies in his or her handwriting that a specific brand is "medically necessary"** for a particular recipient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A checkoff box on a form is not acceptable. The "brand necessary" documentation requirement applies to telephoned prescriptions. **This certification authorizes the pharmacist to fill the prescription with the requested brand name product and not to dispense the generic product listed in the Virginia Voluntary Formulary.**

In addition, the DMAS has established a Virginia Maximum Allowable Cost for some multiple-source drugs listed in the Virginia Voluntary Formulary which are not designated as federal maximum allowable drugs. Again, unless the physician follows the procedures outlined above for specifying a brand necessary drug, the Virginia Maximum Allowable Cost per unit will be used to determine the allowable payment.

Denial of Payment for Early Refills and Therapeutic (Class) Duplication in Certain Drug Categories

DMAS has an early refill denial edit and therapeutic (class) duplication edit as an enhancement of the Medicaid ProDUR activities requirement. These Point-of-Service (POS) edits expand ProDUR activities to include the denial of unjustified requests for early prescription refills or therapeutic (class) duplicate products. In the unusual situations identified below, a mechanism has been provided for override of the denial.

"Early refill" is defined as "when a prescription refill is requested before 75% of the calculated days' supply has elapsed for the previously filled prescription. " Providers must take extra care in verifying that a correct amount is shown for the "days' supply" entry for all prescriptions.

Additionally, a denial edit for therapeutic duplication will occur when a product in the same therapeutic drug class as a concurrently utilized product (e.g., concurrent use of two calcium channel blockers) is billed. The following groups of drugs will be subject to therapeutic duplication alerts:

- ACE Inhibitors;
- Antidepressants;
- Anti-Ulcer;
- Benzodiazepines;
- Calcium Channel Blockers;
- Cardiac Glycosides;
- Diuretics; and
- Non-Steriodal Anti-Inflammatory Drugs (NSAIDs).

A payment denial code will require the provider to reverse the claim denial in those cases where a valid reason can be documented for the need to override the denial.

In the following unusual circumstances, the pharmacist may override the denial:

A. Only the following reasons may be used as justification for override of early refill edits:

1. "**Temporary Exemption**" **-** Need determined by travel distance, transportation availability, or travel out of area;
2. "**Missing Medication**" **-** Waste, spilled, lost, stolen, destroyed, or damaged drug supply;
3. "**Data Entry Error (days' supply)** " **-** Keying error or underestimation of use pattern; and
4. "**Clinical Justification**" **-** Dose increase authorized by the prescriber, etc.

B. Only the following reasons may be used as justification for override of the therapeutic duplication edit:

1. "**Original Drug Discontinued. New Drug Ordered.** " **-** Discontinued use of one drug and subsequent new prescription issued in the same therapeutic drug class (e.g., substitution of one calcium channel blocker for another); and
2. "**Physician Contacted, Deems Duplicate Therapy Necessary.**" - Pharmacist's professional judgment still must be used to ensure the patient will not be at risk from such duplication.

Pharmacy Coverage for Outpatients Including Payment for Certain Over-the-Counter (OTC) Products When Used as Therapeutic Alternatives to More Costly Legend Drugs and Payment Methodology for OTC Products and Oral Contraceptives

Previous coverage of pharmaceuticals for Virginia Medicaid recipients in the outpatient setting allowed coverage of OTC family planning drugs and supplies, as well as insulin, syringes, and needles. After extensive expert panel review and public comment, the Board of Medical Assistance Services (BMAS) determined that certain categories of over-the-counter (OTC) products also may be used appropriately as less costly therapeutic alternatives to certain categories of prescription-only (legend) drugs.

The purpose of this initiative is to allow the use of cost-saving alternatives in the prescription program, not to allow general coverage of all OTC products. Therefore, these products should only be prescribed for outpatients **when the provider otherwise would have used a more expensive legend product**. Note that it is possible to titrate the dose of many of these agents. In this manner, health professionals may choose to adjust the dose or product to suit the individual needs of the patient.

The choice of whether or not to use these additional products will be determined by the patient's prescribing health care provider. This expansion of OTC coverage in the outpatient population will not affect the current coverage standards for categories of drugs included for OTC coverage in the nursing facility environment.

Effective for dates of service on and after February 1, 1997, additional OTC categories of products available for selected outpatients are:

Analgesics, oral
Antacids
Antidiarrheals
Antifungals, topical
Antihistamines
Anti-infective agents, vaginal
Anti-inflammatory agents, oral
Antiulcer preparations
Hematinics
Hydrocortisone, topical
Laxatives, bulk producers, stool softeners
Pediculocides/Scabicides
Vitamins, pediatric (in established deficiencies)
Vitamins, prenatal
Vitamins or minerals for dialysis patients

Requests for OTC products will be handled in the same manner as prescriptions. The order may be written as a prescription or transmitted to the pharmacy by any other means which complies with the regulations of the Board of Pharmacy. Documentation is handled in the same manner as prescription drug orders. If the order is not received as a written document, the information must be reduced to writing and filed sequentially, as with any legend drug order. All requirements for storage and retrieval of documents must be observed. The product must be labeled according to the prescriber's order and appropriate counseling must be offered to the patient.

DMAS must rely on the expert professional judgment of our providers to use this cost-saving opportunity to the best advantage. In the interest of an easy implementation of this initiative, the OTC products will be handled in the same manner as legend drug orders, with no additional documentation required. An analysis of utilization by category of product and provider will be undertaken. Evidence of inappropriate OTC use could stimulate the use of additional program constraints.

Products covered under this program must be supplied by companies participating in the HCFA Medicaid rebate program.

Reimbursement for Medications Showing Obsolete NDC Numbers

DMAS will consider current, active NDC (National Drug Code) numbers for reimbursement of medication charges.

Medication charges for products bearing obsolete NDC numbers will be denied. Numbers determined to be obsolete are based on notification in quarterly updates from the Health Care Financing Administration's Drug Rebate Program.

Regardless of the use of any commercial computer data updating service, each provider is personally responsible for submissions which are correct in all details. Failure to maintain a complete, current record of product NDCs may result in delays as providers must resubmit corrected claims denied for obsolete products.

To be assured of proper, timely reimbursement, providers should check each stock package used against the billing to be submitted. It is important to be sure that billings are made based on actual stock used.

Medicare Catastrophic Coverage Act of 1988
[Effective Date: January 1989]

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB--MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE."

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for **all**

Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

Drug Utilization Review Program

State and federal legislation created the directive for the Virginia Medicaid Drug Utilization review (DUR) program. The purpose of the OBRA 90 DUR Program is to ensure that prescriptions for outpatient drugs are appropriate, are medically necessary, and are not likely to cause adverse results. OBRA 90 further requires that the DUR Program be designed to educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care. DMAS has established a DUR Board to review and approve drug use criteria and standards for both retrospective and prospective DURs; apply these criteria and standards in the performance of DUR activities; review and report the results of DURs; and recommend and evaluate educational intervention programs. The DUR Board has selected DUR criteria that are representative of clinically important issues. The focus of these criteria is on high-risk, high-volume, and high-cost drugs.

Under the OBRA 90 federal mandate, retrospective DUR is required for outpatients. However, because of a State legislative mandate for nursing facility retrospective DUR, nursing facility patients are also included in the retrospective component of the DUR Program. The criteria used for the nursing facility population is tailored to the needs of the elderly; the data for the outpatient and nursing facility populations will be analyzed and reported separately.

Prospective DUR (prospective review, patient counseling, and patient profiling) is required only for outpatients. Patient counseling is not required for inpatients of a hospital or institution where a nurse or other caregiver authorized by the Commonwealth is administering the medication.

The impact of the DUR Program on Medicaid providers varies. The retrospective component is primarily focused on prescribing patterns and is likely to have more of an effect on physicians and other prescribing providers. The pharmacist is responsible for performing the activities required for the prospective component. As a result, pharmacy providers will be affected by prospective DUR to a greater degree than prescribing providers.

DMAS Retrospective Drug Utilization Review Program
[Effective: February 13, 1992]

The DMAS Retrospective Drug Utilization Review Program (DUR) was developed in response to the 1990 Appropriations Act of the Commonwealth of Virginia and involves retrospective reviews focused on covered drugs prescribed for Medicaid patients residing in nursing homes. The primary objectives of the nursing home DUR Program are improvement in the quality of care and conservation of Medicaid funds.

Quarterly audits are used to conduct the DUR Program. The criteria and standards used to perform the quarterly computerized DUR audits are approved by an interdisciplinary DUR Committee consisting of six physicians, five pharmacists, and two long-term care nurses. The DUR Committee is also responsible for the manual review of patient profiles identified as exceptions to the audit criteria. If the DUR Committee feels that the information contained in an excepted profile should be communicated to the provider, a letter will be sent to the appropriate prescriber and the consulting pharmacist. In many cases, the letter will be purely informational; in other situations, clarification may also be requested from the provider. Each time a DUR audit is performed, a computerized summary report of the numbers of excepted cases will be generated for each nursing facility and sent to the administrator of the facility. During this entire process, the identities of the resident, prescriber, pharmacist, and nursing facility will remain confidential. After providers have had an opportunity to respond to the DUR Committee's letter, the Committee will meet to determine if further educational efforts are necessary. These activities may range from visits to individual providers to continuing education opportunities for providers in general.

RECIPIENT APPEALS OF DENIAL OF SERVICES

Any denial of a service decision made by DMAS staff must be appealed to DMAS. This decision must be appealed in writing by the recipient or his or her legally appointed representative. If possible, please include a copy of the denial with the appeal request. All appeals must be filed within 30 days of the date of the final decision notification. Appeals should be directed to:

Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219